[Current Date]

[Recipient Name or Department]
[Credentialing/Licensing Board Name]
[Organization Address]
[City, State, Zip Code]

RE: Health Care Provider Certification for [Provider Full Name]

To Whom It May Concern,

Please find the enclosed documentation and application for the Health Care Provider Certification of [Provider Full Name]. [Provider Name] is currently [employed by/contracted with] [Clinic Name] as a [Job Title, e.g., Physician, Nurse Practitioner, Physical Therapist].

Our clinic has verified the following credentials for this provider:

- Medical License Number: [License Number]
- National Provider Identifier (NPI): [NPI Number]
- Board Certifications: [List Certifications]
- Education and Training: [Degree and Institution]

We certify that [Provider Name] is in good standing with our facility and meets all internal requirements for clinical privileges and patient care. The attached documents include the completed application form, proof of malpractice insurance, and relevant transcripts as required by your office.

We kindly request that you process this certification at your earliest convenience. Should you require any additional information or have questions regarding this application, please contact our administrative office at [Phone Number] or via email at [Email Address].

Thank you for your assistance in this matter.

Sincerely,

[Signature]
[Print Name]
[Title, e.g., Medical Director or Clinic Manager]
[Clinic Name]